

**REPORT FROM
THE
ETHICS COMMITTEE
OF THE
PREMIER'S COUNCIL ON THE
STATUS OF DISABLED PERSONS**

**440 King Street, Suite 648
Fredericton, N.B. E3B 5H8**

DECEMBER, 1997



TABLE OF CONTENTS

SETTING THE CONTEXT	1
MEDICAL ETHICS.....	3
SOME OF THE LEGAL ISSUES	3
RESPONSE OF THE PREMIER'S COUNCIL ON THE STATUS OF DISABLED PERSONS.....	6
DEFINITIONS	7
INTRODUCTION TO ISSUES	9
MISSION STATEMENT	10
CONCLUSIONS.....	12
APPENDIX I : Relevant Provisions of the Criminal Code of Canada and the Civil Code of Quebec.....	A1
APPENDIX II : List of Selected Statutes from New Brunswick that may be Relevant to our Work.....	A13

SETTING THE CONTEXT

Persons with disabilities are disturbed by recent trends and events in Canada and the United States that may pose threats to their personal human rights and even their lives in certain situations.

Media publicity given to the activities of Dr. Jack Kevorkian has raised the topics of assisted suicide, euthanasia and patient rights to new dimensions. We are also seeing more examples of extreme right wing groups promoting the return of the narrow philosophies of purity and selection such as those that led to the Holocaust under the Nazi regime of World War II. The subject of eugenics and euthanasia is becoming commonly discussed once again in Canada and elsewhere in the world.

Canada has also become entangled into the debates of moral choices and quality of life arguments by the Sue Rodriguez case from British Columbia which went all the way to the Supreme Court of Canada. She had amyotrophic lateral sclerosis and was challenging the current section of the Criminal Code of Canada preventing assisted suicide. The September 30, 1993 court decision ruled that her appeal should be dismissed on the grounds that the Criminal Code did not violate the Canadian Charter of Rights and Freedom. In the end, Mrs. Rodriguez did carry out her assisted suicide in 1994 despite the results of the court trials.

On October 24, 1993, Robert Latimer of Saskatchewan used carbon monoxide poisoning to end the life of his twelve year old daughter, Tracy, who was significantly disabled with cerebral palsy. In November 1994, he was convicted of second degree murder which carried a mandatory sentence of life imprisonment without eligibility for parole for ten years. Before serving any jail time, his case was appealed. That appeal was dismissed by the Saskatchewan Court of Appeal in July 1995. A further appeal was then launched to the Supreme Court of Canada. Some irregularities with the screening of potential jurors in his original trial provided grounds for a new trial to be ordered. The new trial was completed in Saskatchewan in November of 1997. The new jury found him guilty of second degree murder. On December 2, 1997, the judge took the unusual step of granting a constitutional exemption and imposed a sentence of only two years less a day.

Mary Jane Fogarty of Halifax was convicted in 1994 of aiding and abetting a suicide by helping her friend, Brenda Barnes, commit suicide with an insulin overdose. Although she was the first person in Canada to be convicted of this charge, she was

given a suspended sentence.

In February of 1994, the *Special Senate Committee on Euthanasia and Assisted Suicide* began its work into those topics from a Canadian context. Their report was completed in June 1995. It recommended that involuntary euthanasia remain an offence under the Criminal Code but did recommend a new category of offence for "mercy killings" which could have a lesser penalty than options currently available.

On May 7, 1997, Dr. Nancy Morrison of the Queen Elizabeth II Hospital in Halifax was charged with first degree murder in the death of Paul Mills who was a cancer patient from Moncton. The crown prosecutor in this case has indicated they wish to reduce the charges before going to trial. Other patient cases of suspected euthanasia or possible physician assisted suicide are now under investigation at the same hospital. This particular situation has generated a great deal of publicity, and some members of the medical community are actively lobbying for changes to the Criminal Code to eliminate murder charges for so-called mercy killings.

Prior to the recent federal election, Senator Sharon Carstairs introduced a bill in the Senate to protect from criminal liability health care providers who gave "medication in dosages that might shorten the life of a person ...". That bill died on the order paper due to the election call, but she has indicated she will be introducing a new version of that bill in the Senate as soon as she can.

Canadians with disabilities have also been affected by changes to health care services and reductions to community-based support programs that would enable them to live with dignity and equity. There are some who feel that citizens with special needs are becoming increasingly disadvantaged and devalued, and are being perceived as an expensive, unnecessary drain on public resources. Furthermore, the difficulties in accessing home care support services and/or quality palliative care may lead people to choices that they would not otherwise have made. Persons often fear that they will die in extreme pain and/or with the loss of personal dignity in the final stages of a terminal illness.

Progress made in social and economic inclusion seems to be sliding away from persons with disabilities who fear that decisions by someone else will impact more and more on their quality of life and perhaps even their life itself if they do not meet some arbitrary community standard of acceptable health and levels of independence.

People with disabilities are afraid of being seen as an expense to the system and not as

individual human beings with rights and value to the community. Wherever possible, they wish to be able to make informed decisions that will control the directions of their care and life experiences. As a society, we must be especially careful when delegating authority to someone else or to some bureaucracy to make life and death decisions on behalf of another person deemed incapable of making decisions for themselves.

MEDICAL ETHICS

Medical ethics are moral guidelines for doctors governing good professional conduct. The basic aims are considered to be :

- ▶ doing good.
- ▶ avoiding harm.
- ▶ preserving the patient's autonomy.
- ▶ telling the truth.
- ▶ pursuing justice.

Ethical issues provoke the most discussion in medicine where these five aims cannot be simultaneously achieved, for example, where what is "good" for a child may clash with his or her autonomy or that of the parents.

Traditionally these principles have been set out in the Hippocratic Oath (introduced by the Greek physician Hippocrates and including such injunctions as the command to preserve confidentiality, to help the sick to the best of one's ability, and to refuse fatal drafts), but in the late 20th century rapidly advancing technology has raised the question of how far medicine should intervene in natural processes.

- (CD Rom) Family Doctor, 1994

SOME OF THE LEGAL ISSUES

We should be aware that the current status of the law, and more importantly if and how the law will be enforced, can vary tremendously from legal jurisdiction to legal jurisdiction.

The police and/or the criminal justice system must make decisions whether a situation should even be investigated, let alone have charges brought forward. There is also a certain amount of leeway in terms of what specific charges will be laid even in similar

situations.

If the case goes to trial, will the legal evidence be sufficient to gain a conviction and if so, what level of penalty will be imposed.

For example, if we examine Appendix I, we can see there are a number of different possible charges under the Criminal Code of Canada with vastly different penalties if one is found guilty. Also, we must remember that judges have a major role in determining the amount of sentence received except in situations where a minimum mandatory sentence goes with a guilty verdict.

The current publicity associated with the Latimer case in Canada has raised the idea that our Criminal Code should be amended to add a third category of murder to be used in so-called "mercy killing" cases. The penalty for this offence would supposedly give more latitude for less severe sentencing options compared to the current sentences available under first or second degree murder verdicts.

Other jurisdictions outside Canada have also made some important legislative or judicial decisions that touch on the issue of assisted suicide or euthanasia.

In the Netherlands, for almost 20 years the courts have not convicted doctors who assist in suicides at the explicit request of the patient. In February of 1992, the Dutch parliament moved to give doctors the legal right to do so if they follow strict guidelines for second opinions.

However, a 1991 study found that in one year more than 1,000 Dutch patients who were not capable of giving consent died at their doctor's hands. That finding supported fears that making assisted suicide legal could become a means to meet social or economic goals. (Time Magazine, May 31, 1993)

Australia's Northern Territory became the first place in the world to legalize voluntary euthanasia. On September 22, 1996, the first death came under the Rights of the Terminally Ill Act. Bob Dent received a fatal injection of drugs at his request due to his terminal cancer. However, that state legislation has been under legal challenge even before Mr. Dent's death. (Time Magazine, October 7, 1996)

This law lasted only nine months before being overturned by Australia's national parliament. Four people died using the Northern Territory law.

However, in July of 1997 the South Australian state parliament upper house passed the first step in enacting another voluntary euthanasia bill. Under the bill, adults of sound mind could request a lethal injection, either immediately if terminally ill or in the future if they become terminally ill.

Their request would need to be witnessed by a doctor who would certify the patient did not suffer from a treatable clinical depression, and two witnesses. Then 48 hours later, a second doctor would certify the request and the injection could go ahead. This proposed law goes further than the first territory law which required three doctors' signatures which proved difficult to get and prevented some terminally ill patients from using the first law before it was overturned.

On June 26, 1997 the Supreme Court of the United States unanimously **rejected** the arguments that terminally ill people have a constitutional right to doctor assisted suicide.

Chief Justice William H. Rehnquist, whose wife died in 1991 after a long battle with ovarian cancer, wrote the decisions for the court which also upheld state laws in Washington and New York, which make it a crime for doctors to give life-ending drugs to mentally competent but terminally ill patients who no longer want to live.

Chief Justice Rehnquist said the notion that having another's help in bringing about your own death conflicts with "our nation's history, legal traditions and practices."

"The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it", he added in discussing the Washington state law. (US News Bulletin, August 1997)

Voters in the state of Oregon had approved measures to enable a physician to legally help a terminally ill person commit suicide in 1994. Opponents challenged the law in court and obtained an injunction until the legal issues were resolved. The U.S. Supreme Court dismissed the legal challenge earlier this fall and a public referendum showed 60 percent public support of those who voted to retain the law in that state. It is expected that the state law will be challenged in court. (Globe and Mail, November 6, 1997)

As of 1990, forty U.S. states have living wills laws that allow people to specify in advance what treatments they would find acceptable in their final days. (Time

Magazine, March 19, 1990)

It was already legal in the U.S. for doctors to withhold or withdraw treatment at a patient's request. (Time Magazine, April 15, 1996)

We can certainly see that the law is constantly evolving and how it will be interpreted and how it will be enforced are difficult to predict with absolute certainty.

For some of the other related legal issues to consider here in New Brunswick, we refer you to the selected provincial statutes listed in Appendix II, in addition to the Relevant Provisions of the Criminal Code of Canada and the Civil Code of Quebec previously referred to in Appendix I.

RESPONSE OF THE PREMIER'S COUNCIL ON THE STATUS OF DISABLED PERSONS

The members of the Premier's Council on the Status of Disabled Persons in New Brunswick have been concerned about the continuing debate of these issues and wanted to develop current information on the topics of euthanasia, assisted suicide and patient rights from the particular perspective of persons with disabilities.

A special committee has been formed by the Council to develop this research and formulate positions. We have chosen to refer to our group as the *Ethics Committee*.

We recognize that such topics are very complex and can generate great emotions depending on the personal experiences of the readers of our commentary.

Religious and cultural backgrounds also make it difficult for people to share the same values when it comes to issues related to dying.

The Premier's Council on the Status of Disabled Persons will not be able to generate consensus on every aspect of these complicated subjects, but we hope to ensure a more balanced debate by sharing information and different perspectives.

Our goal is to ensure that governments at all levels, the medical profession and the public-at-large act in a manner that respects the value, the dignity and the rights of all citizens; especially for persons with disabilities.

DEFINITIONS

For future reference, the Premier's Council on the Status of Disabled Persons has decided to accept the following definitions as contained in the report, *Of Life and Death*, produced by the Special Senate Committee on Euthanasia and Assisted Suicide in June 1995 in Canada.

"Competent" means capable of understanding the nature and consequences of the decision to be made and capable of communicating this decision.

"Incompetent" means not capable of understanding the nature and consequences of the decision to be made and/or not capable of communicating this decision.

"Involuntary" means done *against* the wishes of a competent individual or a valid advance directive.

"Non-voluntary" means done *without the knowledge* of the wishes of a competent individual or of an incompetent individual.

"Voluntary" means done *in accordance with* the wishes of a competent individual or a valid advance directive.

"Palliative care" is care aimed at alleviating suffering - physical, emotional, psychosocial, or spiritual - rather than curing. It is concerned with the comfort of the suffering individual.

"Assisted suicide" is the act of intentionally killing oneself with the assistance of another who provides the knowledge, means, or both.

"Euthanasia" is a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person's suffering where that act is the cause of death.

"Advance directive", referred to as mandate in the *Quebec Civil Code*, and also commonly known as a living will, is a document executed by a competent individual concerning health care decisions to be made in the event that the individual becomes incompetent to make such decisions. Advance directives can be divided into two categories - instruction directives and proxy directives. The latter are also known as

durable powers of attorney for health care. In an instruction directive, an individual sets out *what or how health care decisions are to be made* in the event that he or she becomes incompetent. In a proxy directive, an individual sets out *who is to make health care decisions* in the event that he or she becomes incompetent. A valid advance directive is one completed according to the requirements set out in the relevant legislation. Throughout this Report, when the expression advance directive is used, validity is assumed unless otherwise indicated.

"Surrogate decision-maker" is someone who is authorized by law or by a person, through a power of attorney, for example, or is appointed by a court to make treatment decisions on behalf of an incapable person.

"Free and informed consent" means the voluntary agreement by a person who in the possession and exercise of sufficient mental capacity, as defined by an appropriate medical professional, makes an intelligent choice as to treatment options. It supposes knowledge about the consequences of having or not having the treatment and about possible alternatives. The consent must be free from coercion, duress and mistake.

The Premier's Council on the Status of Disabled Persons has accepted these definitions and would like to draw particular attention to the differences in the explanation of the terms "assisted suicide" and "euthanasia". These are two very distinct concepts and should not be used as interchangeable words as has been the case in various media reports. The inappropriate use by the media of these two words have served to confuse the issues for the public and perhaps for some legislators.

Other terms used in our commentary will be defined as we use them in the context of our observations.

INTRODUCTION TO ISSUES

Many citizens would rather avoid the subject of death, but it is part of the natural cycle of life.

Advances in medical technology seem to have raced ahead of our moral and legal understanding of the ethics associated with choices about quality of life and when and how our individual lives will end.

Physicians and other caregivers are caught up in the emerging debate as to when life sustaining treatment should be initiated, maintained or terminated. As citizens, do we have the right to determine ourselves when we are ready to die even if we need physical assistance to carry out that wish? Perhaps more importantly, should anyone else be allowed to make such choices for another when the person to be affected cannot explicitly express their own wishes now?

Persons with disabilities are extremely interested in such debates as they are often in situations where others have been making choices either directly or by implication for them. They look back at the eugenics movement in Germany, which was supported by the medical community in such a way that it led to wholesale euthanasia of persons with disabilities even before the opening of the nazi death camps.

We must pay particular attention to the concepts of informed consent, competency and the process of delegation of consent to third parties. The Canadian legal system needs further reform in these areas, but only after a vigorous public debate that understands the full implications of any changes that might be made through legislative means.

We must not allow the issues of euthanasia, assisted suicide and patient rights to be determined after the fact by ad hoc rationalizations or the outcomes of specific court cases.

The media and the Internet are full of articles and discussions on these topics, but the political will to clarify these sensitive issues seems to be lacking both in government and medical circles.

While many would argue that a legally competent and conscious adult should have the right to make choices as to how and when to end their lives, we are not clear as to the process to determine competency. Should it matter if they are emotionally depressed

as a result of suffering from a spinal cord injury or the death of their elderly spouse?

Should a cooling off period be necessary? Should counselling be mandatory? Should a second medical opinion be required automatically before life support systems are removed or physician assisted suicides allowed?

How often should advance directives be updated and what legal protection should they provide to caregivers or family members who might have a conflict over their responsibilities or inheritance?

Especially troubling is what duty of care is required for an incompetent person, someone in a coma, or a child not yet of legal age of consent? Does a parent's or family member's rights to make decisions supersede the right to life of that individual?

The Premier's Council on the Status of Disabled Persons will be exploring these and other issues as we refine our examination on such ethical and legal issues. We are expecting a summary of legal issues relating to mental competence to be released soon by the **Public Legal Education and Information Service of New Brunswick**.

In the meantime, we have already confirmed our commitment to the following statement that will guide our deliberations in the future.

MISSION STATEMENT

"All persons have an inalienable right to life and self-determination."

(Approved by Council in November 1996)

What do we mean when we use the term "**inalienable**"? In reviewing constitutional law and the subject of rights, we know that there are different types of rights and different ways to decide how to identify and/or enforce a right. A civil right is a right given and protected by law and a person's enjoyment, therefore, is regulated by the law that created it. [Nickell vs Rosenfield 82 Cal. App. 369,375 (1927)]

An inalienable right is a more powerful expression of a natural right that is to be enjoyed by all persons. Such a right is not open to the discretion of the government of the day, the whims of the medical profession or the interference of the community at large who may share different values as to what is good or bad.

"You have rights antecedent to all earthly government; rights that cannot be repealed or restrained by human laws; rights derived from the Great Legislator of the Universe."
(John Adams)

We believe all human beings are born with certain non-negotiable inherent natural rights.

The basic right to life is an inalienable right that must be carefully and strongly protected for every individual in our society. It must not matter if an individual's current health status or the presence of a disability may be perceived by others as having somehow reduced the quality and value of life for that individual. Only that person should be able to decide what is the quality of their life. We should not allow others in society the option of using their values to make judgements about the relative value of someone else's life.

We would like to quote from a report prepared by "The Arc's Self-Determination Program" funded by the U.S. Department of Education :

"Self-determination refers to "acting as a causal agent in one's life and making choices and decisions regarding one's quality of life free from undue external influence or interference." (Wehmeyer 1992)

- ▶ Self-determination is highly valued in our society. People who are self-determined make choices based on their preferences, beliefs and abilities, take control over and participate in decisions which impact the quality of their lives, take risks and assume responsibility for their actions, and advocate on behalf of themselves and others. Self-determination is one marker of adulthood, and self-determined people are viewed as worthy of respect and valued by others.
- ▶ Self-determination is believing you can control your own destiny. Self-determination is a combination of attitudes and abilities that lead people to set goals for themselves, and to take the initiative to reach these goals. It is about being in charge, but is not necessarily the same thing as self-sufficiency or independence. It means making your own choices, learning to effectively solve problems, and taking control and responsibility for one's life. Practicing self-determination also means one experiences the consequences of making choices."

Only those found guilty of breaking the laws of the society should be open to the

judgement of others as to their future disposition.

Therefore, it is the position of the Premier's Council on the Status of Disabled Persons that **"All persons have an inalienable right to life and self-determination"**.

CONCLUSIONS

The Premier's Council on the Status of Disabled Persons is not planning to get involved at this time with the abortion/right to life debate. We are following the current Canadian law that indicates that a fetus becomes a legal person only after leaving the womb.

What the Council does want to do by raising the issues discussed in this paper is to clearly convey the message that persons with disabilities have the same rights and should be treated in the same manner as all other citizens. We do not accept a different standard of law for persons with disabilities. The life of a person with a disability has the same value as one for any citizen.

Bearing in mind our Mission Statement that "ALL PERSONS HAVE AN INALIENABLE RIGHT TO LIFE AND SELF-DETERMINATION", it seems obvious that the Council also clearly supports the following expression of rights for all citizens :

**"NO PERSON HAS THE RIGHT TO UNILATERALLY TERMINATE
THE LIFE OF ANOTHER PERSON."**

The Premier's Council on the Status of Disabled Persons is not ready to comment further on the separate specific topic of assisted suicide as we have not yet reached consensus amongst the members in our discussions on that difficult subject.

APPENDIX

- I Relevant Provisions of the Criminal Code of Canada and the Civil Code of Quebec.**
- II List of selected statutes from New Brunswick that may be relevant to our work (as of November 8, 1996).**

APPENDIX I

Relevant Provisions of the Criminal Code of Canada and the Civil Code of Quebec

Criminal Code

The subject areas that were identified as being dealt with, directly or indirectly, in the Code are : (1) pain control and sedation practices, (2) withholding and withdrawal of life-sustaining treatment, (3) assisted suicide, and (4) euthanasia. Furthermore, although certain portions of the provisions may not appear to relate directly to the conduct described, the sections have not, for the most part, been abridged in light of the fact that each provision should be read in its entirety in order to better appreciated its purpose.

Consent to Death

14. No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Surgical Operations

45. Every one is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if
- (a) the operation is performed with reasonable care and skill; and
 - (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

Duty of Persons to Provide Necessaries

215. (1) Every one is under a legal duty
- (a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;

- (b) as a married person, to provide necessities of life to his spouse; and
- (c) to provide necessities of life to a person under his charge if that person
 - (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
 - (ii) is unable to provide himself with the necessities of life.
- (2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies upon him, to perform that duty, if
 - (a) with respect to a duty imposed by paragraph (1)(a) or (b),
 - (i) the person to whom the duty is owed is in destitute or necessitous circumstances, or
 - (ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or
 - (b) with respect to a duty imposed by paragraph 1(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.
- (3) Every one who commits an offence under subsection (2) is guilty of
 - (a) an indictable offence and is liable to imprisonment for a term not exceeding two years; or
 - (b) an offence punishable on summary conviction.

Duty of Persons Undertaking Acts Dangerous to Life

216. Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable

knowledge, skill and care in doing so.

Duty of Persons Undertaking Acts

217. Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.

Criminal Negligence

219. (1) Every one is criminally negligent who

(a) in doing anything, or

(b) omitting to do anything that it is his duty to do,

shows wanton or reckless disregard for the lives or safety of other persons.

(2) For the purposes of this section, "duty" means a duty imposed by law.

Causing Death by Criminal Negligence

220. Every one who by criminal negligence causes death to another person is guilty of an indictable offence and is liable to imprisonment for life.

Causing Bodily Harm by Criminal Negligence

221. Every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

Homicide

222. (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.

(2) Homicide is culpable or not culpable.

(3) Homicide that is not culpable is not an offence.

- (4) Culpable homicide is murder or manslaughter or infanticide.
- (5) A person commits culpable homicide when he causes the death of a human being,
 - (a) by means of an unlawful act,
 - (b) by criminal negligence,
 - (c) by causing that human being, by threats or fear of violence or by deception, to do anything that causes his death, or
 - (d) by wilfully frightening that human being, in the case of a child or sick person.

Murder

229. Culpable homicide is murder

- (a) where the person who causes the death of a human being
 - (i) means to cause his death, or
 - (ii) means to cause him bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not;
- (b) where a person, meaning to cause death to a human being or meaning to cause him bodily harm that he knows is likely to cause his death, and being reckless whether death ensues or not, by accident or mistake causes death to another human being, notwithstanding that he does not mean to cause death or bodily harm to that human being; or
- (c) where a person, for an unlawful object, does anything that he knows or ought to know is likely to cause death, and thereby causes death to a human being, notwithstanding that he desires to effect his object without causing death or bodily harm to any human being.

Classification of Murder

231. (1) Murder is first degree murder or second degree murder.
- (2) Murder is first degree murder when it is planned and deliberate.
- ...
- (7) All murder that is not first degree murder is second degree murder.

Manslaughter

234. Culpable homicide that is not murder or infanticide is manslaughter.

Punishment for Murder

235. (1) Every one who commits first degree murder or second degree murder is guilty of an indictable offence and shall be sentenced to imprisonment for life.
- (2) For the purposes of Part XXIII [Punishments], the sentence of imprisonment for life prescribed by this section is a minimum punishment.

Punishment for Manslaughter

236. Every one who commits manslaughter is guilty of an indictable offence and liable to imprisonment for life.

Counselling or Aiding Suicide

241. Every one who

- (a) counsels a person to commit suicide, or
- (b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

Administering Noxious Thing

245. Every one who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence and liable

- (a) to imprisonment for a term not exceeding fourteen years, if he intends thereby to endanger the life of or to cause bodily harm to that person; or
- (b) to imprisonment for a term not exceeding two years, if he intends thereby to aggrieve or annoy that person.

Assault

265. (1) A person commits an assault when

- (a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly;
- (b) he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe upon reasonable grounds that he has, present ability to effect his purpose; or

...

(2) This section applies to all forms of assault, including sexual assault, sexual assault with a weapon, threats to a third party or causing bodily harm and aggravated sexual assault.

(3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of

- (a) the application of force to the complainant or to a person other than the complainant;
- (b) threats or fear of the application of force to the complainant or to a person other than the complainant;
- (c) fraud; or

(d) the exercise of authority.

- (4) Where an accused alleges that he believed that the complainant consented to the conduct that is the subject-matter of the charge, a judge, if satisfied that there is sufficient evidence and that, if believed by the jury, the evidence would constitute a defence, shall instruct the jury, when reviewing all the evidence relating to the determination of the honesty of the accused's belief, to consider the presence or absence of reasonable grounds for that belief.

266. Every one who commits an assault is guilty of

- (a) an indictable offence and liable to imprisonment for a term not exceeding five years, or
- (b) an offence punishable on summary conviction.

Assault Causing Bodily Harm

267. (1) Every one who, in committing an assault,

...

- (b) causes bodily harm to the complainant,

is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

- (2) For the purposes of this section and sections 269 and 272, "bodily harm" means any hurt or injury to the complainant that interferes with the health or comfort of the complainant and that is more than merely transient or trifling in nature.

Aggravated Assault

268. (1) Every one commits an aggravated assault who wounds, maims, disfigures or endangers the life of the complainant.

- (2) Every one who commits an aggravated assault is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

Unlawfully Causing Bodily Harm

269. Every one who unlawfully causes bodily harm to any person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

Sentence of Life Imprisonment

742. Subject to s.742.1 [Power of court to delay parole], the sentence to be pronounced against a person who is to be sentenced to imprisonment for life shall be

- (a) in respect of a person who has been convicted of high treason or first degree murder, that he be sentenced to imprisonment for life without eligibility for parole until he has served twenty-five years of his sentence;
- (a1) in respect of a person who has been convicted of second degree murder where that person has previously been convicted of culpable homicide that is murder, however described under this Act, that he be sentenced to imprisonment for life without eligibility for parole until he has served twenty-five years of his sentence.
- (b) in respect of a person who has been convicted of second degree murder, that he be sentenced to imprisonment for life without eligibility for parole until he has served at least ten years of his sentence or such greater number of years, not being more than twenty-five years, as has been substituted therefore pursuant to section 744; and
- (c) in respect of a person who has been convicted of any other offence, that he be sentenced to imprisonment for life with normal eligibility for parole.

Civil Code

**Title Two
Certain Personality Rights**

**Chapter I
Integrity of the Person**

Art. 10 Every person is inviolable and is entitled to the integrity of his person.

Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent.

**Section I
Care**

Art. 11 No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.

If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place.

Art. 12 A person who gives his consent to or refuses care for another person is bound to act in the sole interest of that person, taking into account, as far as possible, any wishes the latter may have expressed.

If he gives his consent, he shall ensure that the care is beneficial notwithstanding the gravity and permanence of certain of its effects, that it is advisable in the circumstances and that the risks incurred are not disproportionate to the anticipated benefit.

Art. 13 Consent to medical care is not required in case of emergency if the life of the person is in danger or his integrity is threatened and his consent cannot be obtained in due time.

It is required, however, where the care is unusual or has become useless or where its consequences could be intolerable for the person.

- Art. 14 Consent to care required by the state of health of a minor is given by the person having parental authority or by his tutor.

A minor fourteen years of age or over, however, may give his consent alone to such care. If his state requires that he remain in a health or social services establishment for over twelve hours, the person having parental authority or tutor shall be informed of that fact.

- Art. 15 Where it is ascertained that a person of full age is incapable of giving his consent to care required by his state of health, consent is given by his mandatory, tutor or curator. If the person of full age is not so represented, consent is given by his spouse or, if he has no spouse or his spouse is prevented from giving consent, it is given by a close relative or a person who shows a special interest in the person of full age.

- Art. 16 The authorization of the courts is necessary, furthermore, to cause a minor fourteen years of age or over to undergo care he refuses, except in the case of emergency if his life is in danger or his integrity threatened, in which case the consent of the person having parental authority or the tutor is sufficient.

- Art. 17 A minor fourteen years of age or over may give his consent alone to care not required by the state of his health; however, the consent of the person having parental authority or of the tutor is required if the care entails a serious risk for the health of the minor and may cause him grave and permanent effects.

- Art. 18 Where the person is under fourteen years of age or is incapable of giving his consent, consent to care is not required by his state of health is given by the person having parental authority or the mandatory, tutor or curator; the authorization of the court is also necessary if the care entails a serious risk for health or if it might cause grave and permanent effects.

- Art. 19 A person of full age who is capable of giving his consent may alienate a part of his body *inter vivos*, provide the risk incurred is not disproportionate to the benefit that may reasonably be anticipated.

A minor or a person of full age who is incapable of giving his consent may, with the consent of the person having parental authority, mandatary, tutor or curator and with the authorization of the court, alienate a part of his body only if that part is capable of regeneration and provided that no serious risk to his health results.

Art. 20 A person of full age who is capable of giving his consent may submit to an experiment provided that the risk incurred is not disproportionate to the benefit that can reasonably be anticipated.

Art. 21 A minor or a person of full age who is incapable of giving his consent may be submitted to an experiment only in the absence of serious risk to his health and of objection on his part, provided that he understands the nature and consequences of the act; the consent of the person having parental authority or of the mandatary, tutor or curator is necessary.

An experiment may be carried out on one person alone only if a benefit to the health of that person may be expected, and the authorization of the court is necessary.

An experiment on a group of minor persons or incapable persons of full age shall be carried out within the framework of a research project approved by the Minister of Health and Social Services, upon the advice of an ethics committee of the hospital designated by the Minister or of an ethics committee created by him for that purpose; in addition, such an experiment may be carried out only if a benefit to the health of persons of the same age group and having the same illness or handicap as the persons submitted to the experiment may be expected.

Care considered by the ethics committee of the hospital concerned to be innovative care required by the state of health of the person submitted to it is not an experiment.

Art. 22 A part of the body, whether an organ, tissue, or other substance, removed from a person as part of the care he received may, with his consent or that of the person qualified to give consent for him, be used for purposes of research.

- Art. 23 When the court is called upon to rule on an application for authorization with respect to care, the alienation of a part of the body, or an experiment, it obtains the opinions of experts, of the person having the parental authority, of the mandatary, of the tutor or the curator and of the tutorship council; it may also obtain the opinion of any person who shows a special interest in the person concerned by the application.

The court is also bound to obtain the opinion of the person concerned unless that is impossible, and to respect his refusal unless the care is required by his state of health.

- Art. 24 Consent to care not required by a person's state of health, to the alienation of a part of a person's body, or to an experiment shall be given in writing.

It may be withdrawn at any time, even verbally.

- Art. 25 The alienation by a person of a part or product of his body shall be gratuitous; it may not be repeated if it involved a risk to his health.

An experiment may not give rise to any financial reward other than the payment of an indemnity as compensation for the loss and inconvenient suffered.

APPENDIX II

**List of selected statutes from New Brunswick
that may be relevant to our work (as of November 8, 1996) :**

- ▶ Advanced Life Support Services Act
- ▶ Age of Majority Act
- ▶ Conflict of Laws Rules for Trusts Act
- ▶ Corrupt Practices Inquiries Act
- ▶ Custody and Detention of Young Persons Act
- ▶ Elections Act
- ▶ Evidence Act
- ▶ Executors and Trustees Act
- ▶ Family Income Security Act
- ▶ Family Services Act
- ▶ Fatal Accidents Act
- ▶ Guardianship of Children Act
- ▶ Health Act
- ▶ Hospital Act
- ▶ Hospital Services Act
- ▶ Human Rights Act

- Human Tissue Act
- Infirm Persons Act
- Limitation of Actions Act
- Medical Consent of Minors Act
- Mental Health Act
- Ombudsman Act
- Presumption of Death Act
- Provision for Dependents Act
- Right to Information Act
- Survival of Actions Act
- Wills Act
- Workers' Compensation Act
- Workplace Health, Safety and Compensation Commission Act



